2004 COMMONWEALTH OF MASSACHUSETTS
ENROLLMENT / CHANGE FORM
DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)

EMPLOYEE INFORMATION / DIRECT DEPOSIT AUTHORIZATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	SOCIAL SECURITY NUMBER

CITY	STATE	ZIP

DATE OF BIRTH	☐ SINGLE ☐ MARRIED	WORK PHONE	HOME PHONE	EMAIL ADDRESS

BANK NAME	ROUTING NUMBER	ACCOUNT NUMBER	☐ CHECKING ☐ SAVINGS

Please complete the appropriate box below. See reverse side of this form for additional information.

OPEN ENROLLMENT

☐ **YES** I choose to participate in the DCAP Plan. I authorize my Employer to deduct the amount specified below.

$_____ ANNUAL ELECTION
will be divided over each pay period during the year

To be completed by Payroll Coordinator:
# of pay periods in the year: 27 Deduction Amt: _____

NEW HIRE

☐**YES** I choose to participate in the DCAP Plan. I authorize my Employer to deduct the amount specified below.

$_____ ANNUAL ELECTION
will be divided over each pay period during the year

To be completed by Payroll Coordinator:
# of pay periods remaining in the year: _____ Deduction Amt: _____
Date of Hire: _____

CHANGE IN STATUS

Complete this section to add or drop participation in the Dependent Care Assistance Plan (DCAP).

☐**YES** I choose to participate in the DCAP Plan. I authorize my Employer to deduct the amount specified below.

☐**YES** I choose to cancel my election.

$_____ ANNUAL ELECTION
will be divided over each pay period during the year

To be completed by Payroll Coordinator:
# of pay periods remaining in the year: _____ Deduction Amt: _____
Change of Status Date: _____

AUTHORIZATION TO PARTICIPATE / CHANGE

I understand that I may not increase or decrease the amount of my income reduction until the next Plan Year, except to reflect a change in my family status. In making contributions to this spending account I understand that I will forfeit any amount in my account if I do not incur eligible expenses for it by the end of the Plan Year. This election replaces any previous election and will terminate on the earlier of (1) the end of the Plan Year; (2) when I am no longer being compensated in an amount at least equal to my total salary reduction; (3) termination of the Plan. My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code. I choose to have my reimbursements made to me via direct deposit. I authorize Sentinel Benefits to make deposits to my bank account indicated above.

SIGNATURE _____ DATE: _____

PAYROLL COORDINATOR VERIFICATION

Effective Payroll Date: _____ Name: _____

Agency Name: _____ Department ID #: _____ / _____

Phone #: _____ Fax #: _____ Email: _____

IMPORTANT INFORMATION REGARDING ENROLLMENT AND CHANGES

Administrative Fee:
The cost to administer this program is paid for by each employee on a before tax basis. The monthly administrative fee is $4.50 – for DCAP alone or DCAP and the Health Care Spending Account (HCSA) combined.

Annual Maximum:
The IRS guidelines limit the annual election in the DCAP program to $5,000. This account may only be used for dependent care situations while you (and your spouse, if married) work. You may also participate if your spouse is a full-time student or disabled.

Newly Hired Employees:
Employees hired during the plan year are eligible on the first day of employment and may elect the full $5,000. Enrollment forms must be submitted to your Payroll Coordinator within 30 days from your date of hire.

Change in Status:
You may change your contribution election at the beginning of each plan year. You may only change your election during the plan year if you can demonstrate a "change in status." Only the following events will be considered a valid change in status under Internal Revenue Service rules:

- Change in legal marital status;
- Change in number of dependents;
- Change in employment status;
- Change in work schedule which changes your eligibility for the program;
- Dependent satisfies or ceases to satisfy eligibility requirements;
- Change of residence or work-site; and
- Judgment, decree or order pertaining to child or spouse.

If you would like to terminate your election as a result of a valid status change, enter a zero dollar amount in the Change in Status section of the enrollment form. Payroll Coordinators must obtain the appropriate documents for a Change in Status, e.g. marriage or birth certificate.

Signature and Form Submission:
The employee and Payroll Coordinator must sign this form. All forms must be submitted to the Payroll Coordinator at your work site. The Payroll Coordinator must send a copy of the form to Sentinel Benefits.

Eligible Expenses under a Dependent Care Assistance Plan:
Eligible expenses under a Dependent Care Assistance Plan are defined as those that enable the participant and the participant's spouse to work or to look for work. They include the following:

1. Child care centers that care for six or more children and that meet the IRS's definition of a qualified day care center;
2. Caregivers for a disabled spouse or dependent who lives with the participant;
3. Babysitters;
4. Nursery schools;
5. Day Camp; and
6. Household expenses, provided that a portion of such expenses are incurred to ensure a qualifying dependent's well-being and protection.

Note: In compliance with the IRS guidelines, the service provider cannot be an individual for whom a personal tax exemption may be claimed. In addition, a child of the participant or spouse cannot be under the age of 19.

***Ineligible* Expenses under a Dependent Care Assistance Plan:**

1. Babysitting for social events;
2. Educational expenses; and
3. Charges for overnight camp.